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Attorneys for Defendant
UNITEDHEALTHCARE INSURANCE COMPANY

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

DR JOHN ATTENELLO MD APC,

Plaintiff,

v.

UNITED HEALTHCARE INSURANCE COMPANY,

Defendant.

Case No.:

DECLARATION OF JANE STALINSKI IN SUPPORT OF NOTICE OF REMOVAL

[*Filed concurrently with Notice of Removal and Civil Cover Sheet*]

I, Jane Stalinski, declare as follows:

1. I am a resident of Cuyahoga County in the State of Ohio. I am over the age of 18 years, of sound mind, and fully competent to make this Declaration.

2. I am a Senior Legal Services Specialist and an authorized representative of UnitedHealthcare Insurance Company ("UHIC") and its affiliates. As part of my duties and responsibilities, I manage a team that has access to, and reviews, business records maintained in the regular course of business. I make this Declaration in support of the Notice of Removal concurrently filed UHIC.

3. I base my statements contained herein upon my personal knowledge and from information obtained from various sources, including based on my team's review of corporate and business records and business documents contemporaneously maintained in the regular and ordinary course of business, and therefore, except as stated upon information and belief, know these statements to be true.

4. Based on the allegations in the Complaint, certain business records were reviewed and compiled.

5. Business records maintained in the ordinary course of business confirm that at the time of the at-issue date of service, the patient/member identified as "Mehrnaz A." in the Complaint, participated in an AARP Supplemental and Personal Health plan (the "Mehrnaz A. Plan"), which is insured and administered by UHIC, at the time of the at-issue date of service. The Mehrnaz A. Plan is governed by Medicare. Attached hereto as **Exhibit A** is a true and correct copy of the Mehrnaz A. Plan describing the Plan's terms.

6. Business records maintained in the ordinary course of business confirm that UHIC is organized under the laws of Connecticut with its principal place of business in Connecticut—this information is set forth in public corporate filings.

7. Business records maintained in the ordinary course of business confirm that UHIC provides administrative services for insurance products, including health benefits plan for employer groups governed by the Employee Retirement Income Security Act ("ERISA"). UHIC also contracts as a Medicare Advantage Organization with the federal

Department of Health and Human Services Centers for Medicare and Medicaid Studies to administer federal Medicare insurance benefits under the federal Medicare Advantage program.

8. Business records maintained in the ordinary course of business confirm that UHIC is licensed by the Insurance Commissioner of the State of California. UHIC is not licensed as a "Health Care Service Plan" by the California Department of Managed Health Care.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 12th day of March 2025.

Jane Stalinski

Jane Stalinski

EXHIBIT A

AARP'S MEDICARE SUPPLEMENT PLAN G

Underwritten by

UnitedHealthcare Insurance Company

Horsham, Pennsylvania

Issued to:

CONTINUING YOUR COVERAGE: This coverage is guaranteed renewable which means that it cannot be canceled except for nonpayment of Premium, termination of the Group Policy, or material misrepresentation. Statements made by you in the application were relied upon in the issuance of this coverage. If any statement is incorrect or untrue, UnitedHealthcare has the right to rescind this coverage, adjust Premiums or reduce benefits. **If you are aware of any incorrect or incomplete information, you should contact UnitedHealthcare now, before any claim arises.**

Otherwise, you may keep your plan in force by paying the required Premium when due. The required Premium for this plan is subject to change. Any change will apply to all members of the same class insured under this plan who reside in your state at that time. If the Group Policy terminates, you will be offered coverage through another insurance carrier or an individual conversion policy issued by UnitedHealthcare (see "Conversion Privilege").

30 DAY RIGHT TO EXAMINE YOUR COVERAGE: If you decide you do not want this coverage, you may return this Certificate within 30 days after receiving it. Upon receipt, your insurance will be deemed void from its Effective Date and any Premium payments made will be returned to you. However, UnitedHealthcare has the right to recover any claims paid during this period. Any Premium refund otherwise due to you will be reduced by the amount of any claims paid during this period. If you have received claim payment in excess of the amount of your Premium, no refund of Premium will be made. The Certificate, together with a written request for such withdrawal, must be sent to: UnitedHealthcare, PO BOX 30607, Salt Lake City, UT 84130–0607.

NOTICE TO BUYER: This plan may not cover all of your medical expenses.

PRE-EXISTING CONDITIONS LIMITATION: A pre-existing condition is a condition for which medical advice was given or treatment was recommended by or received from a Physician within 3 months prior to your plan's Effective Date. Any expenses incurred during the first 3 months after your Effective Date will not be considered if due to a pre-existing condition.

If you have replaced qualifying coverage (as indicated on the application for this plan), you will receive notice of that portion of your plan's pre-existing conditions limitation period that has been waived due to the length of time your prior coverage was in effect. No benefits will be payable under this plan for any stay or medical care for which benefits are payable under your prior plan.

This pre-existing conditions limitation will not apply if your application was received by UnitedHealthcare prior to or during the 6-month period beginning with the first day of the month in which you turned age 65 and enrolled in Medicare Part B, or if mandated by state law.

This pre-existing conditions limitation will not apply when you meet the Open Enrollment/Guaranteed Issue requirements as shown on page 7.

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ABOUT THIS COVERAGE

UnitedHealthcare Insurance Company ("UnitedHealthcare"), Horsham, Pennsylvania, has issued Group Policy No. G-36000-4 to the TRUSTEES OF THE AARP INSURANCE PLAN, Washington, D.C. The Group Policy is delivered in and governed by the laws of the District of Columbia and provides insurance for members of AARP. All benefits are subject to the entire Group Policy which includes the Group Insurance Certificates.

This Certificate is an important document and should be kept in a safe place. You may not enroll in this plan if it duplicates benefits provided under another Medicare Supplement plan.

This plan does not duplicate benefits paid by Medicare. The deductible and Coinsurance amounts for Medicare Supplement insurance benefits paid by your plan will automatically change when Medicare's deductibles and Coinsurance requirements change.

WHO IS ELIGIBLE FOR COVERAGE – EFFECTIVE DATE

To enroll for coverage under this plan, an individual must be an eligible member of AARP or an eligible spouse of a member, and must be enrolled under both Part A and Part B of Medicare. Coverage begins on the Effective Date shown on the first page of this Certificate. The required Premium must be paid when due. Medicare Eligible Expenses must be incurred on or after the Effective Date in order to be considered under this plan.

If you request a change that affects this coverage, such change will be effective on the first day of the month following the date we receive your request for such change, subject to UnitedHealthcare's approval.

DESCRIPTION OF TERMS

Coinsurance – The portion or percentage of the Medicare-approved amount that a beneficiary is responsible for paying.

Hospice Care – Care for those who are terminally ill. Hospice Care typically focuses on comfort (controlling symptoms and managing pain) rather than seeking a cure.

Hospital – A Medicare-approved institution that provides care for which Medicare pays hospital benefits.

Injury – A bodily injury which is the direct result of an accident or intentional act, independent of disease or bodily infirmity or any other cause.

Inpatient Hospital Deductible – The amount due from a patient upon the first admission to a Hospital in each Medicare Benefit Period, before benefits are available under Part A of Medicare.

Lifetime Reserve Days – You have a lifetime reserve of 60 days for Medicare Part A inpatient hospital care. These days may be used whenever more than 90 days of inpatient hospital care are needed in a Medicare Benefit Period.

Medicaid – A program of medical assistance for the poor and indigent, established under Title XIX of The Social Security Act.

Medicare – Parts A and B of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medicare Benefit Period – A period of time as defined in the Medicare program for the determination of eligibility for Medicare Part A benefits.

Medicare Eligible Expenses – Expenses of the kinds covered by Medicare Parts A and B. The expenses must be reasonable and medically necessary according to Medicare's standards for payment.

Medicare Part B Deductible – The amount you must pay each calendar year before Part B of Medicare pays benefits for Part B Medicare Eligible Expenses.

Physician – A licensed practitioner of the healing arts who is acting within the scope of his or her license.

Premium(s) – The monthly payment required for each member in accordance with this plan.

Sickness – Any illness or disease of an insured person.

Skilled Nursing Facility – A facility that provides skilled nursing care and is approved for payment by Medicare.

DESCRIPTION OF BENEFITS

Payment of benefits is subject to all of the terms and conditions of this plan.

Hospital Stays – UnitedHealthcare will pay the following benefits for covered days of inpatient Hospital stays which occur on or after the Effective Date of this plan:

(1) Medicare Part A Deductible: UnitedHealthcare will pay benefits for the Medicare Part A Inpatient Hospital Deductible amount per Medicare Benefit Period;
(2) Coverage for the Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare (the daily Coinsurance amount) from the 61st day through the 90th day in each Medicare Benefit Period;
(3) Coverage for the Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare (the daily Coinsurance amount) for each Medicare Lifetime Reserve Day used;

(4) After all Medicare inpatient hospital benefits are exhausted, including the Lifetime Reserve Days, coverage for the Part A Medicare Eligible Expenses incurred for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance.

In no event will any benefits be paid for any period of a Hospital stay that occurs prior to the Effective Date of this plan.

Blood – UnitedHealthcare will pay benefits under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) per calendar year, unless replaced in accordance with federal regulations.

Part B Medicare Eligible Expenses – UnitedHealthcare will pay benefits for the Coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Part B Medicare Eligible Expenses, regardless of hospital confinement, after the Medicare Part B Deductible has been met. Part B Medicare Eligible Expenses must be incurred on or after the Effective Date of this plan. Only those charges determined by Medicare to be Medicare Eligible Expenses will be covered under this plan.

Hospice Care – UnitedHealthcare will pay benefits for the cost-sharing for all Part A Medicare eligible Hospice Care and respite care expenses.

Skilled Nursing Facility Stays – UnitedHealthcare will pay the Coinsurance amount, from the 21st day through the 100th day in a Medicare Benefit Period, which is incurred on or after the Effective Date of this plan for post-hospital Skilled Nursing Facility care eligible under Medicare Part A.

100% of the Medicare Part B Excess Charges – UnitedHealthcare will pay benefits for the difference between the actual Medicare Part B charge as legally billed (not to exceed any charge limitation established by the Medicare program or state law) and the Medicare-approved Part B charge.

Foreign Travel Medical Emergency Care – UnitedHealthcare will pay benefits, to the extent not covered by Medicare, for 80% of the billed charges for Medicare Eligible Expenses for hospital, physician and medical care received in a foreign country due to a Medical Emergency, if such care would have been covered by Medicare if provided in the United States. Such care must begin during the first 60 consecutive days of each Trip outside the United States. Payment of this benefit is subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. Benefits are payable only if the Medical Emergency care is received on or after the Effective Date of this plan. Benefits for Foreign Travel Medical Emergency Care will be payable in United States currency in an amount based on the bank transfer exchange rate in effect on the day claim payment is processed by UnitedHealthcare. It is your responsibility to provide an itemized bill and any necessary medical records relevant to the claim that are requested by UnitedHealthcare.

For the purposes of the Foreign Travel Medical Emergency Care benefit, the following definitions apply:

Medical Emergency – The sudden and unexpected onset of symptoms, Sickness, Injury or a condition that would be deemed, under appropriate United States medical standards, to carry substantial risk of serious medical complication or permanent damage to you if care or services are withheld.

Trip – A period of time beginning the day you leave the United States and ending the day you return.

GENERAL EXCLUSIONS

These exclusions apply to your coverage.

Benefits Provided Under Medicare – UnitedHealthcare will only pay benefits as described in this Certificate. In no event will benefits under this plan duplicate benefits provided under Medicare or which would have been provided had a claim for services been submitted to Medicare.

Care Not Meeting Medicare's Standards – For an expense to be considered for payment, the stay or service must meet the Medicare program standard; Medicare's conditions, limitations and exclusions apply unless otherwise specifically stated within this Certificate. In the event that the Medicare program changes to provide coverage for different care or services, this coverage will be amended accordingly.

Charges In Excess of Medicare Eligible Expenses – This plan will not cover expenses for services or supplies in excess of what Medicare determines or would have determined is a covered service and a Medicare Eligible Expense, except as provided under the "100% of the Medicare Part B Excess Charges" provision.

Care For Which You Have No Obligation To Pay – No benefits are provided for stays, care or visits for which no charge would be made to you in the absence of insurance, or for which you have no legal obligation to pay.

Government Hospitals – This plan will not cover a stay, service, supply or facility provided by a hospital or other institution owned or operated by a national government, or any other government, unless payment of the charge is required by law.

Workers' Compensation – This plan will not cover any injury or sickness for which you are entitled to any benefits under workers' compensation or similar law.

WHEN YOU HAVE A CLAIM

Claim Filing – Instructions for filing claims were sent to you after you enrolled. You should show your insurance card to your health care provider to facilitate claim filing. Medicare may release claim information to UnitedHealthcare to enable benefits to be processed automatically. For Medicare Eligible Expenses, UnitedHealthcare must receive confirmation from the Medicare carrier which shows the Medicare Eligible Expenses.

Proof of Loss – Benefits are payable when UnitedHealthcare receives satisfactory proof of loss. Proof must be furnished not later than 15 months from the date of the loss, except in the absence of legal capacity.

Payment of Claims – UnitedHealthcare will pay benefits directly to the person or provider who provided the care for which benefits are payable when your Medicare or your plan benefits are assigned. Benefits not assigned will be paid to you, unless otherwise required by law.

If any benefit remains payable after your death or while you are not competent to give a valid release, UnitedHealthcare may pay a benefit up to $3,000 to any relative of yours whom UnitedHealthcare decides to be justly entitled to it. Any payment made to your relative in good faith will fully release UnitedHealthcare of its responsibility to the extent of the payment.

Physical Examination – When you submit a claim, UnitedHealthcare, at its own expense, has the right to examine you as often as it may reasonably require while the claim is pending.

Medical Records – When you submit a claim, any provider who provided care may release to UnitedHealthcare all medical information and records which relate to the claim, and UnitedHealthcare has the right to receive and review such information and records. UnitedHealthcare will treat all such information and records as confidential.

Legal Actions – No legal action may be brought once three years, or the period of time in the applicable statute of limitations, has passed, whichever period is longer.

Benefits Provided Under Another Plan – If this coverage replaces Medicare Supplement insurance coverage, no benefits will be paid under this plan for any stay or care for which benefits are payable under any continuation or extension of benefits provision of the prior coverage.

Cessation of Medicare Coverage – If you cease to be insured under either Part A or Part B of Medicare, UnitedHealthcare will pay benefits as if you remained insured under both Part A and Part B of Medicare.

Effect of Change of Plan – If, on the Effective Date, you have changed to a new plan from any other AARP plan issued by UnitedHealthcare (the prior plan), no benefits will be paid under your new plan to the extent that benefits are payable under your prior plan.

Non-Duplication of Benefits – Only one type of benefit provided in this plan is payable for any covered stay or service.

Recovery of Claims Paid – If UnitedHealthcare makes a payment with respect to services and such payment or a portion thereof is not required according to the terms of this plan, UnitedHealthcare shall have the right to recover such overpaid amounts from any of the following: any person to or for or with respect to whom the payments were made; any insurance company; or any other organization or person.

When Medicare Is Secondary – If you have other health insurance which is determined to be primary to Medicare, then benefits payable under this plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

GENERAL MATTERS

Statements Made By You – The Certificate, any riders which may be issued or attached, your application, and the Group Policy constitute the entire contract. Statements made by you to obtain insurance under this plan will be deemed representations and not warranties. These statements will not be used in a contest to avoid your insurance, adjust Premiums or reduce benefits unless: 1) it is in a written statement signed by you; and 2) a copy of that statement is or has been furnished to you or your legal representative.

If you have misstated your age, eligibility, health conditions, or other material facts and this Certificate would not have been issued had that information been correctly stated, this Certificate is void. UnitedHealthcare will refund all Premiums paid less the amount of any claims paid under this Certificate.

If you have misstated your age, eligibility, health conditions, or other material facts and a different Premium would have been charged had that information been correctly stated, you are responsible for payment of the correct Premiums from the Effective Date of this Certificate. In addition to other rights granted under this Certificate, UnitedHealthcare shall have the right to offset against any claim amounts otherwise payable to recover that portion of Premiums owed by you but not paid as the result of your misstatement.

These statements, except fraudulent misstatements, will not be used in a contest after your insurance has been in force, prior to the contest, for at least two years. After two years, only fraudulent misstatements may be used to contest your coverage.

Grace Period – Upon payment of your first Premium, you have 31 days after the Premium due date to pay any subsequent required Premium. Your coverage under this plan will stay in force until the end of this period. In any case, you must pay the Premium for coverage in force during the Grace Period. If you replace this plan with any other AARP health plan issued through UnitedHealthcare, coverage under this plan will stop on the Effective Date of your new plan and this 31 day grace period will not apply.

Group Health Plan Suspension – If you are under age 65 and entitled to benefits under Medicare Part A by reason of disability, the benefits and Premiums under your AARP Medicare Supplement insurance plan will be suspended, at your request, while you are covered under a group health plan. Benefits and premiums will be suspended for a period of time not to exceed the time period provided by federal regulation. If this Medicare Supplement plan is suspended according to this provision, and you lose your coverage under the group health plan, your plan will automatically be reinstated if you provide UnitedHealthcare with notice of loss of the group health plan coverage within 90 days after the date of such loss. Your plan may be reinstated as of the date you lose your coverage under the group health plan, provided you pay Premiums for that period.

If you make such request for reinstatement, the reinstated coverage: 1) shall not provide for any new waiting period with respect to treatment of pre-existing conditions; 2) shall provide for coverage under the same plan (if available) or under a plan which provides substantially equivalent coverage; and 3) shall, for rate purposes, keep you grouped in the same class.

Inspection of Policy – The Group Policy is on file at the office of the Trustees of the AARP Insurance Plan located at 601 E Street, N.W., Washington, DC 20049. It may be inspected during normal business hours.

Medicaid – The benefits and premiums under your AARP Medicare Supplement Plan may be suspended during your entitlement to benefits under Medicaid for up to 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon your request, if you are no longer entitled to Medicaid, your plan will be reinstated if you make such request within 90 days of the date you are no longer entitled to Medicaid. Your plan may be reinstated as of the date you lose Medicaid entitlement, if you pay premiums due for that period.

If you make such request for reinstatement, the reinstated coverage: 1) shall not provide for any new waiting period with respect to treatment of pre–existing conditions; 2) shall provide for coverage under the same plan (if available) or under a plan which provides substantially equivalent coverage; and 3) shall, for rate purposes, keep you grouped in the same class.

Multiple Coverage – This Certificate replaces any certificate that may have been previously issued to you to supplement Medicare under the Group Policy (No. G-36000-4). You may not have more than one AARP plan to supplement Medicare through UnitedHealthcare at any one time.

Conformity With State Statutes – Any provision in this Certificate which, on its Effective Date, conflicts with the laws of the state in which it is delivered is amended to meet the minimum requirements of such laws.

BENEFITS AFTER YOUR COVERAGE STOPS

If your coverage under this plan ends, benefits will continue for any continuous loss which began while your insurance was in force. Any extension of benefits beyond that time will be conditioned upon your continuous total disability. Total disability means that you are confined under a Physician's orders in an institution or at home for medical care or treatment and that you are unable to engage in the normal and customary activities of a person of the same age and sex in reasonably good health. Such benefits will be limited to the lesser of payment for the duration of this plan's benefit period or payment of maximum benefits, and are subject to all other provisions set forth in this Certificate. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE

If your coverage stops because the Group Policy terminates, and is not replaced by another group plan providing the same type of coverage, you may convert your coverage to an individual Medicare Supplement policy (the converted policy). You must apply for the converted policy, and pay the first premium within 31 days after you receive notice of your conversion rights, or within 31 days after the coverage under this plan stops if later.

OPEN ENROLLMENT

The pre-existing conditions limitation as described on page 1 will not apply if you qualify for one of the open enrollment periods described below.

You may qualify for a six-month Open Enrollment period in the following ways:

- The first six months you are enrolled in Medicare Part B (if initial enrollment in Part B is before age 65, there is a second six-month Open Enrollment period at age 65).
- Following notice or effective date of termination of your employer coverage, or loss of eligibility for such coverage due to divorce or your spouse's death.
- Following your loss, or loss of access to, military retiree coverage due to base closure, termination of services by the base, or the retiree's change of residence.
- Following your loss of Medicare supplement (including Medicare Select) coverage due to change of residence to a location not served by the plan.
- Following your loss of eligibility for Medicaid due to increased income or assets.

Following your loss of a Medicare Advantage plan, you are entitled to an additional 60-day open enrollment period.

When you replace another Medicare Supplement plan (including Medicare Select) during your birthday month, you are entitled to an annual one-month open enrollment period. Your enrollment application must be received during the month prior to, during, or the month after your birthday month.

GUARANTEED ISSUE

The pre-existing conditions limitation as described on page 1 will not apply if you qualify for one of the guaranteed issue events as described below.

Your acceptance in any plan is guaranteed during your Medicare supplement open enrollment period which lasts for 6 months beginning with the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

You may qualify for a Guaranteed Issue in the other following ways:

1. You lose, learn you have lost, or drop employer coverage, or your employer plan no longer covers all of the Medicare Part B coinsurance.
2. You are enrolled in a Medicare Advantage (MA), PACE, Medicare Select, Medicare Cost or a healthcare prepayment plan and:
   - The plan stops coverage in the area,
   - The plan sends notice it will stop coverage, or
   - You move out of the service area
3. You are enrolled in a MA, PACE, Medicare supplement (including Select), Medicare Cost or a healthcare prepayment plan and the plan:
   - Violates the insurance contract (for example, by failing to provide necessary medical care), or
   - Was misrepresented in marketing to the individual
4. You are enrolled in a Medicare supplement plan (including Select) that is involuntarily terminated (for example, company bankruptcy).
5. You dropped your Medicare supplement coverage to enroll in a MA, PACE, or Select plan, and dropped that plan within two years.
6. On first enrolling in Medicare Part A at age 65, you enrolled in a MA or PACE plan, and dropped that plan within two years.
7. Your Medicare Advantage (or PACE, Medicare cost, health care prepayment plan, or Medicare Select policy) plan:
   - Reduces benefits
   - Increases premiums by 15% or more
   - Raises copayments for physician or hospital services or drugs by 15% or more
   - Discontinues, for other than good cause relating to the quality of care, its relationship or contract under the MA plan with a provider who is currently furnishing services to the individual.

   NOTE: This Guaranteed Issue requirement only applies to individuals not currently enrolled in a UnitedHealthcare/Secure Horizons Medicare Advantage plan and there are no Medicare supplement plans available from their Medicare Advantage issuer. These individuals may only enroll in an AARP Medicare Supplement Plan during the Annual Election Period (AEP) for a Medicare Advantage plan except where the

Medicare Advantage plan has discontinued its relationship with a provider currently furnishing services to the individual.

8. Your Medicare Advantage (or PACE, Medicare cost, health care prepayment plan, or Medicare Select policy) plan reduces any of its benefits or increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the MA plan with a provider who is currently furnishing services to the individual.

   NOTE: This Guaranteed Issue requirement only applies to individuals enrolled in a UnitedHealthcare/Secure Horizons Medicare Advantage plan.

9. While you were enrolled in a Medicare supplement plan that covers outpatient prescription drugs you enrolled in a Medicare Part D plan during the initial enrollment period and terminated your Medicare supplement plan.

NOTE: Completed applications must be received within 123 days after the qualifying event.

Applications must include “notice of creditable coverage” (employer plans) or “notification of rights” (Medicare Advantage plans).

CONTACT INFORMATION

To obtain information or discuss a concern:

You may call UnitedHealthcare Insurance Company’s Toll-free telephone number at:

1-800-523-5800

You may also write to UnitedHealthcare Insurance Company at:

UnitedHealthcare
PO BOX 740807
Atlanta, GA 30374-0807

If you are not satisfied with the resolution of your question or concern after discussing it with UnitedHealthcare, you may contact the California Department of Insurance at:

1-800-927-4357

You may write the California Department of Insurance at:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES AND MARKET CONDUCT BRANCH
CONSUMER SERVICES DIVISION
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013

Web: www.insurance.ca.gov